## Return completed form to the GIC Coordinator at your Benefits Office. Do not return to the GIC

## **Initial Insurance Enrollment Form – Medicare Retirees/Survivors**

□□ TRANSPORTATION										
Insured's GIC-ID (usually Soc. Sec. #)		Sex: Date of Birth		Birth	Dept. ID # or Agency/Division #		Check one: For Agency Use Only		For Agency Use Only	
		Female			/		Retiree			
Name - Last			First		MI			Date of retirement/		
□ □ Survivor										
Address City State Zip Code										
Home Phone										
Retirees: Do you receive a monthly retirement pension from the MBTA?										
BASIC LIFE & HEALTH COVERAGE Effective Date: /01							Date: / 01 /			
New Enrollment	Decline Coverage		Cancel Coverage		Insured's Medicare cla	im number:	1			
☐ Basic Life and Health (Select one of the health plans below and individual or family coverage) ☐ Basic Life Only Note: Survivors not eligible for Basic Life										
Health Plan – Medicare Retirees/Survivors										
G Fellow Comics Disc. (UMAO) G Total Madisons Complement (UMAO) G Hookk Nov. Feelow MadDisc. (UMAO)										
				•			oui iuo	(111110)	<u>Coverage</u>	
☐ Tufts Med	·	☐ Harvard Pilgrim Medicare Enhance (Indemnity)						□ Individual		
If enrolling in one of these two Medicare plans, the GIC will notify the plan to forward their  UniCare State Indemnity Plan / Medicare Extension (OME)(Indemnity)  Family										
Medicare application to you to complete and return.										
List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. To add a dependent age 19 to 26, you must also complete and return to the GIC a Dependent Age 19 to 26 Enrollment Application. Important: The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, legal separation agreement, and divorce decree for each person you list as a dependent.  Last Name First Middle Relationship Date of Birth Sex Social Security Number (required)										
							Effectiv	e date:		
SPOUSE INFORMATION										
Is your spouse employed?   Yes  No Name of employer Address of employer										
Is your spouse covered under his or her employer's group health insurance plan?										
Policy/Certificate Number Address of insurance company										
Are you and/or your children covered under your spouse's group health insurance plan? You: 🗆 Yes 🗆 No Children: 🗆 Yes 🗀 No										
Is your spouse enrolled in Medicare?   Yes   No If yes, Medicare claim number										
FORMER SPOUSE INFORMATION  Name Social Security Number Date of Birth Date of Divorce										
Last First Middle										
Address Street			City			State			Zip Code	
Is your former spouse remarried?										
Is your former spouse employed?										
Deduction Authorization: I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.										
Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.  Medicare Part B: I understand that if I cancel Medicare Part B coverage, I will no longer be eligible for GIC Coverage.  Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.  Retirees must collect a pension from a public service retirement system to be eligible for GIC coverage.										
Signature of App			Date	Sig	nature of Authorized Officia				Date	
FOR GIC USE ONLY:	Entered		Verified		F	Political Subc	livision			